STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2489AGC	A. BUILDING _____ B. WING _____	11/19/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHANCELLOR GARDENS OF THE LAKE	2620 LAKE SAHARA DRIVE LAS VEGAS, NV 89117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments Surveyor: 27364 The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available under to any party under the applicable federal, state, or local laws. The survey was conducted using Nevada Administrative Code (NAC) 449, Residential Facility for Groups Regulations, adopted by the Nevada State Board of Health on July 14, 2006. This Statement of Deficiencies was generated as a result of the annual state licensure survey and re-survey conducted at your facility on 11/18/09 to 11/19/09. The facility was licensed for 150 total beds, 120 elderly or disabled persons, and/or persons with mental illnesses, and/or persons with chronic illnesses, and 30 persons with Alzheimer's disease, Category II residents. The census at the time of the survey was 109 residents including 27 residents in the Alzheimer's Unit. One hundred seven current resident files and 69 employee files were reviewed. Seventy-eight resident medication records were reviewed. One discharged resident file was reviewed. The facility received a grade of D. The following regulatory deficiencies were identified at the time of the survey:	Y 000		
Y 072 SS=E	449.196(3) Qualications of Caregiver-Med Training	Y 072		

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Y 072	Continued From page 1 NAC 449.196 3. If a caregiver assists a resident of a residential facility in the administration of any medication, including, without limitation, an over-the-counter medication or dietary supplement, the caregiver must: (a) Receive, in addition to the training required pursuant to NRS 449.037, at least 3 hours of training in the management of medication. The caregiver must receive the training at least every 3 years and provide the residential facility with satisfactory evidence of the content of the training and his attendance at the training; and (b) At least every 3 years, pass an examination relating to the management of medication approved by the Bureau. This Regulation is not met as evidenced by: Surveyor: 27364 Based on record review on 11/18/09 and 11/19/09, the facility failed to ensure 4 of 13 caregivers, who were administering medications, completed the required medication management training every three years (Employees #11, #27, #45 and #53). Severity: 2 Scope: 2	Y 072		
Y 103 SS=F	449.200(1)(d) Personnel File - NAC 441A NAC 449.200 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include:	Y 103		

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Y 103	Continued From page 2 (d) The health certificates required pursuant to chapter 441A of NAC for the employee. This Regulation is not met as evidenced by: Surveyor: 27364 Based on record review on 11/18/09 and 11/19/09, the facility failed to ensure 13 of 69 employees complied with NAC 441A.375 regarding tuberculosis (TB) testing including pre-employment physical examinations (Employees #1, #3, #25, #33, #40, #41, #42, #43, #46, #47, #58, #62 and #67). Findings include: Employees #1 and #58 files lacked evidence of a pre-employment physical examination. Employee #3's file had evidence of a negative chest X-Ray on 5/19/08. The file lacked evidence of an initial positive TB skin test and a 2009 annual review of signs and symptoms of TB. Employees #25, #33, #40, #41 and #42 files lacked evidence of an annual one-step TB skin test. Employees #62 and #67 files lacked evidence of an initial two-step TB skin test. Employees #43, #46 and #47 files lacked evidence of an annual review of signs and symptoms of TB. This was a repeat deficiency from the 2/5/09 State Licensure survey.	Y 103		

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Y 103	Continued From page 3 Severity: 2 Scope: 3	Y 103		
Y 105 SS=E	449.200(1)(f) Personnel File - Background Check NAC 449.200 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (f) Evidence of compliance with NRS 449.176 to 449.185, inclusive. This Regulation is not met as evidenced by: Surveyor: 27364 Based on record review on 11/18/09 and 11/19/09, the facility failed to ensure 15 of 69 employees met background check requirements (Employees #26, #27, #31, #32, #35, #41, #42, #43, #52, #53, #54, #56, #57, #60 and #67). Findings include: Employees #26, #27, #31, #32, #35, #52, #53, #56 and #60 files lacked evidence of a State and FBI background report. Employees #41, #42, #43, #54 and #57 lacked evidence of a FBI background report. Employee #67's file lacked copies of fingerprints. Severity: 2 Scope: 2	Y 105		
Y 106 SS=D	449.200(2)(a) Personnel File - 1st aid & CPR	Y 106		

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Y 106	Continued From page 4 NAC 449.200 2. The personnel file for a caregiver of a residential facility must include, in addition to the information required pursuant to subsection 1, (a) A certificate stating that the caregiver is currently certified to perform first aid and cardiopulmonary resuscitation. This Regulation is not met as evidenced by: Surveyor: 27364 Based on record review on 11/18/09 and 11/19/09, the facility failed to ensure 3 of 36 caregivers were trained in first aid and cardiopulmonary resuscitation (CPR) (Employees #14, #21 and #55). This was a repeat deficiency from the 2/5/09 State Licensure survey. Severity: 2 Scope: 1	Y 106		
Y 174 SS=F	449.209(4)(a) Health and Sanitatio-Offensive odors NAC 449.209 4. To the extent practicable, the premises of the facility must be kept free from: (a) Offensive odors. This Regulation is not met as evidenced by: Surveyor: 27364 Based on observation on 11/18/09 and 11/19/09, the facility failed ensure the facility was free of	Y 174		

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Y 174	Continued From page 5 offensive odors in the Alzheimer's unit. Findings include: On 11/1809, and 11/19/09, the Alzheimer's unit had a strong odor of stale urine. Severity: 2 Scope: 3	Y 174		
Y 178 SS=F	449.209(5) Health and Sanitation-Maintain Int/Ext NAC 449.209 5. The administrator of a residential facility shall ensure that the premises are clean and that the interior, exterior and landscaping of the facility are well maintained. This Regulation is not met as evidenced by: Surveyor: 21044 Based on observation on 11/18/09, the facility was not well maintained. Findings include: The bathroom door in bedroom #147 in the Alzheimer's unit was damaged. The ceiling in the dining room was in disrepair, rendering the dining room unusable for all residents. Severity: 2 Scope: 3	Y 178		

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Y 255	Continued From page 6	Y 255		
Y 255 SS=I	449.217(6)(a)(b) Permits - Comply with NAC 446	Y 255		

NAC 449.217
6. A residential facility with more than 10 residents must:
(a) Comply with the standards prescribed in chapter 446 of NAC.
(b) Obtain the necessary permits from the Bureau of Health Protection Services of the Division.

This Regulation is not met as evidenced by:
Surveyor: 27364

Based on observation on 11/18/09, the facility failed to comply with the standards prescribed in chapter 446 of the NAC.

Findings include the following critical violations, which have been shown to substantially increase the risk of foodborne illness, particularly in highly susceptible populations, such as seniors who may be immune compromised.

The person washing the dishes was observed handling soiled tableware, and then removing cleaned and sanitized tableware from the dish machine, without washing his hands between the two activities, thus contaminating the cleaned tableware.

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Y 255	Continued From page 7 The hand sink had been inappropriately removed from the ware washing area. The person in charge of the kitchen at the time of the inspection was not food safety certified, nor was this person able to answer questions that would ensure an appropriate knowledge of food safety and sanitation. Specifically, the person in charge did not correctly answer questions about the proper cooling of foods and she was unable to determine the concentration of sanitizer in the solution used for sanitizing food contact surfaces. The Chef was also unable to provide proof of food safety certification. A food handler was observed rinsing vegetables in the three compartment sink while the sink was full of dirty kitchenware, resulting in potential cross contamination of the vegetables by the soiled kitchenware. A large space was observed under and between the doors exiting from the kitchen to the outside, which increases the potential for pests and dirt to enter the kitchen. Findings also include the following non-critical violations, which relate primarily to equipment and maintenance issues. There was inadequate lighting provided in the dry food storage area (6 foot candles) and in the mixer/prep area (25 foot candles). A wet and soiled mop was left in the bucket in the janitor closet, instead of being rinsed and allowed to air dry. There was no dipper well at the ice cream case in	Y 255		

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Y 255	Continued From page 8 the kitchen to allow for sanitary storage of the ice cream scoop. Household grade refrigerator/freezer, microwave and dish machine were observed in the Memory Care Unit instead of commercial grade equipment. There was evidence that the household dish machine was being used to wash dishware used by residents. The lid on the flour bin was cracked. The top of floor mounted mixer was cracked. The carbon dioxide tank was not secured. The caulking used to seal the kitchen dish machine to the wall was soiled and damaged. The kitchen dish machine hood exhaust vent was dirty/corroded. The garbage disposal had a badly damaged plastic splash shield/safety guard. There was a leaking back flow protector on the mop sink. There was wall damage in the dry storage room. There was a hole in the wall in the food storage room. There was cove tile damage in the kitchen. The ceiling was in disrepair in the janitor closet. The condensate drain line terminated just below the ceiling, rather than draining into a floor sink or other appropriate drain. Severity: 3 Scope: 3	Y 255		
Y 393 SS=D	449.226(4)(a)-(c) Safety Requirements NAC 449.226	Y 393		

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Y 393	Continued From page 9 4. In a residential facility with more than 10 residents: (a) Each resident must be provided with, or the bedroom and bathroom of each resident must be equipped with, an auditory system that is monitored by a member of the staff of the facility. (b) An auditory system must be available for use in the bathroom of each resident of the facility if the facility was issued its initial license on or after January 14, 1997, so that a resident needing assistance can alert a member of the staff of the facility of that fact from the toilet and the shower. (c) A bathroom that is located in a common area of the facility must be equipped with an auditory system that is monitored by a member of the staff of the facility. This Regulation is not met as evidenced by: Surveyor: 27364 Based on observation on 11/18/09 and 11/19/09, the facility failed to ensure the auditory alarm system was continually monitored. The staff failed to respond to 1 of 4 activated resident room alarms (Bedroom #123). Findings include: On 11/18/09 at 8:05 AM, the call alarm was activated in resident room #123. Caregivers failed to respond to the alarm. The central alarm monitor in the medication room showed the alarm had been activated in resident room #123 at 8:05 AM. The central alarm monitor was producing an intermediate alarm beep to alert the caregivers. At 8:23 AM there was still no	Y 393		

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Y 393	Continued From page 10 response by a caregiver to resident room #123. Severity: 2 Scope: 1	Y 393		
Y 693 SS=F	449.2712(2) Oxygen-Caregiver monitor resident ability NAC 449.2712 2. The caregivers employed by a residential facility with a resident who requires the use of oxygen shall: (a) Monitor the ability of the resident to operate the equipment in accordance with the orders of a physician. (b) Ensure That: (1) The resident's physician evaluates periodically the condition of the resident which necessitates his use of oxygen; (2) Signs which prohibit smoking and notify persons that oxygen is in use are posted in areas of the facility in which oxygen is in use or is being stored; (3) Persons do not smoke in those areas where smoking is prohibited; (4) All electrical equipment is inspected for defects which may cause sparks. (5) All oxygen tanks kept in the facility are secured in a stand or to a wall; (6) The equipment used to administer oxygen is in good working condition; (7) A portable unit for the administration of oxygen in the event of a power outage is present in the facility at all times when a resident who requires oxygen is present in the facility; and (8) The equipment used to administer oxygen is removed from the facility when it is no longer needed by the resident.	Y 693		

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Y 693	Continued From page 11 This Regulation is not met as evidenced by: Surveyor: 21044 Based on observation and interview on 11/18/09, the facility failed to ensure the requirements for use of oxygen in the facility were enforced. Findings include: On 11/18/09, Employee #2 and Employee #5 stated there was no smoking inside the facility. The smell of cigarette smoke was detected in resident room #201. When investigated, cigarette ashes were found in the bathroom of bedroom #201. Caregivers did not prevent the resident from smoking in the room. Oxygen tanks were not secured in a rack or to the wall in resident rooms #263, #267 and in the medication room. Severity: 2 Scope: 3	Y 693		
Y 791 SS=F	449.2726(3)(b) Diabetes NAC 449.2726 3. The caregivers employed by a residential facility with a resident who has diabetes shall ensure that: (b) Syringes and needles are disposed of appropriately in a sharps container which is	Y 791		

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Y 791	Continued From page 12 stored in a safe place. This Regulation is not met as evidenced by: Surveyor: 28276 Based on observation 11/18/09 and 11/19/09, the facility failed to ensure syringes and needles were disposed of appropriately in a sharps container stored in a secure location. Findings include: On 11/18/09 and 11/19/09 two sharps containers full of needles were observed with an exposed opening on the floor unsecured in the medication room. Severity: 2 Scope: 3	Y 791		
Y 859 SS=D	449.274(5) Periodic Physical examination of a resident NAC 449.274 5. Before admission and each year after admission, or more frequently if there is a significant change in the physical condition of a resident, the facility shall obtain the results of a general physical examination of the resident by his physician. The resident must be cared for pursuant to any instructions provided by the resident's physician. This Regulation is not met as evidenced by:	Y 859		

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Y 859	Continued From page 13 Surveyor: 27364 Based on record review on 11/18/09 and 11/19/09, the facility failed to ensure 10 of 109 residents received an initial or annual physical examination (Residents #7, #15, #17, #38, #56, #68, #79, #80, #82, and #107). Findings include: Residents #7, #17 and #80 files lacked evidence of initial physical examination. Residents #15, #17, #38, #56, #68, #79, #80, #82 and #107 files lacked evidence of an annual physical examination. This was a repeat deficiency from the 2/5/09 State Licensure survey. Severity: 2 Scope: 1	Y 859		
Y 878 SS=H	449.2742(6)(a)(1) Medication / Change order NAC 449.2742 6. Except as otherwise provided in this subsection, a medication prescribed by a physician must be administered as prescribed by the physician. If a physician orders a change in the amount or times medication is to be administered to a resident: (a) The caregiver responsible for assisting in the administration of the medication shall: (1) Comply with the order.	Y 878		

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Y 878	Continued From page 14 This Regulation is not met as evidenced by: Surveyor: 28276 Based on record review and interview on 11/18/09 and 11/19/09, the facility failed to ensure 25 of 78 residents received medications as prescribed (Resident #5, #11, #12, #14, #20, #23, #39, #41, #43, #46, #49, #52, #56, #61, #62, #66, #70, #80, #88, #89, #91, #93, #94, #105, and #107). It was also determined 9 of 80 residents did not have one or more medications available in the facility during the 12 day period from 11/8/09 to 11/19/09 (Resident #11, #14, #23, #39, #66, #80, #88, #89 and #105). Findings include: Two complaint investigations and this survey were conducted in the facility in the last two months. During the 9/19/09-9/24/09 and 10/20/09-11/2/09 investigations, it was determined resident medication administration records showed significant medications errors by the facility. There were residents who were prescribed medications that were not available in the facility, residents whose medication records did not reflect the current medication orders and did not match the medications available in the facility, and times when facility staff failed to document medication administration to residents. The Administrator reported the facility was unable to obtain current medication orders and re-fills for many residents because the residents had not been seen by a primary care physician. The Administrator reported the facility's plan for residents who did not have current medication prescription was to have them be seen by a physician and obtained new prescriptions for their medications. The facility's Executive Director	Y 878		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 878	Continued From page 15 reported this was accomplished on 11/7/09. A State Licensure survey was initiated on 11/18/09 and completed on 11/19/09. The focus for the review of resident medication administration records (MARs) and resident files was from 11/8/09 through 11/19/09. The medication administration concerns identified during the complaint investigations conducted in September, October and early November of 2009 were found to still be an issue during the survey. A secondary medication administration issue was the facility's use of computerize medication administration records (MARs). The facility was instructed by the Bureau to discontinue the use of the computerized system and revert to printed MARs until such time the Bureau determined the facility was able to consistently provide residents their medications. During the 11/18-19/09 survey, staff provided multiple copies of November MARs for the same resident but printed on different dates. The Wellness Director reported that if a resident had a change to their medications and/or a new medication was added, the changes and/or additions were typed into the computer and a new MAR was printed instead of the changes being hand written on the existing MAR. Reconciliation of resident MARs and medications by surveyors was complicated by staff's use of multiple MARs for the same resident. Surveyors discovered that if a new MAR was generated after 11/1/09 original, some staff were documenting their medication administration on the new MAR, some staff continued to document their medication administration on the old MAR, and some staff were documenting their medication administrations on both the new and the old MARs.	Y 878		

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Y 878	Continued From page 16 Based on the findings during the 11/18-19/09 survey, the Executive Director and facility management has demonstrated their inability to follow through on their corrective plans and denibsterated their continued failure to ensure all residents of the facility were receiving their medications as prescribed. Resident #5: Coumadin 2.5 milligram (mg) one tablet every other day at 5:00 PM and Coumadin 5.0 mg one tablet every other day (a blood thinner). The medication technicians documented that the resident missed three doses of the medication on 11/8/09, 11/11/09 and 11/12/09 by circling their initials on the November 2009 MAR. The medication technicians failed to document a reason for the missed doses. Lorazepam 1 mg one tablet three times a day (for anxiety). The November 2009 MAR listed Lorazepam as an "as-needed" (PRN) medication. The medication technicians documented one dose was given on 11/8/09 and one dose was given on 11/12/09. Advair 100/50 inhale one puff twice a day in the AM and PM (for asthma). The medication technicians documented that the resident missed seven PM doses on 11/8/09, 11/9/09, 11/11/09, 11/12/09, 11/13/09, 11/14/09, 11/15/09 and 11/16/09. The medication technicians failed to document a reason for the missed doses on the November 2009 MAR. Resident #11:	Y 878		

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Y 878	Continued From page 17 Alprazolam (Xanax) .25 mg one tablet every 8 hours PRN (for panic disorder or anxiety). The medication was not available in the facility on 11/18-19/09. The facility would be unable to administer as needed (PRN) medications if the resident needed it. Resident #12: Xopenex HFS inhaler (for asthma). The bottle documented two puffs twice a day, the November 2009 MAR documented two puffs every two hours as needed and the prescription documented two puffs every three hours as needed. Resident #14: Diphenoxylate/Atropine (Lomotil) 2.5 mg two tablets twice a day AM and PM (for diarrhea). The medication technicians documented on the MAR that the resident missed one dose of the medication on 11/16/09 PM because the medication was not available in the facility. The medication technicians left the MAR blank for two AM doses on 11/16/09 and 11/17/09. Without documentation, it is not clear whether the medication was also unavailable on these dates or was not given for some other reason. Resident #20: Lisinopril 5 mg one tablet every day (for hypertension). The medication technicians documented on the MAR that the medication was placed on hold as of 11/1/09, and not given to the resident. The 11/1/09 medication hold order in the resident's file did not include Lisinopril. The resident missed 18 doses of medication from 11/1/09 through	Y 878		

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Y 878	Continued From page 18 11/18/09. Resident #23: Simvastatin 10 mg, one tablet at bedtime (for high cholesterol). The MAR indicated the medication was not available on two occasions, 11/8/09 and 11/11/09. Resident #39: Amlodipine Besylate (Norvasc) 10 mg, one tablet every day at 8:00 AM (for hypertension). The medication was not available in the facility during the survey on 11/19/09 and the resident did not receive the medication as of 5:00 PM on 11/19/09. Employee #2 reported the resident's son had been notified and said he would deliver the medication to the facility. Resident #41: Famotidine (Pepsid) 20 mg, twice a day AM and PM (for heartburn). The medication was not listed on the November 2009 MAR. The resident missed 21 doses of medication from 11/8/09 AM through 11/18/09 AM. Resident #43: Magnesium Citrate 1.75 gram (g)/milliliter (ml) 150 cc, twice a day AM and PM (mineral supplement). The medication technician documented that the resident missed 11 doses of medication by circling their initials on the November 2009 MAR for the PM doses from 11/8/09 through 11/18/09. The medication technicians indicated they thought the medication	Y 878		

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Y 878	Continued From page 19 was to be given only one time a day. Resident #46: Feosol one tablet, twice a day AM and PM (iron supplement). The medication technicians documented on the MAR by circling their initials that the medication was not available for one PM dose on 11/13/09 and one PM dose on 11/14/09. Resident #49: Motrin IB 200 mg, one tablet twice daily AM and PM (for pain). The medication technician documented that the resident missed one PM dose of the medication on 11/8/09 by circling their initials. The medication technician failed to document a reason for the missed dose. Vytorin 10-20 mg, one tablet daily (for high cholesterol). The medication technicians documented that the resident missed one dose of the medication on 11/9/09. The medication technicians failed to document a reason for the missed doses. Ambien 10 mg, one tablet daily at bedtime as needed for sleep (PRN). The medication technicians documented giving the medication to the resident nightly from 11/10/09 to 11/18/19 without reasons why as it was a PRN. Resident #52: Namenda 5 mg, one tablet every day (dementia associated with Alzheimer's disease). Per interview with the medication technicians, the	Y 878		

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Y 878	Continued From page 20 facility was unsure who the doctor was for Resident #52. Review of medication records prior to 11/8/09, showed Namenda was documented as unavailable in October, September and August 2009. There was an arrow drawn across the boxes from 11/1/09 through 11/16/09. The medication was filled 11/13/09. The November 2009 MAR showed the medication was not started until 11/17/09. Divalproex (Depakote) 250 mg, every day (for agitation). The resident received this medication from 11/1/09 through 11/13/09. This medication was filled on 11/13/09 and was not started until 11/17/09. The medication technicians put an arrow throught the boxes on the MAR from 11/13-16/09. The medication technicians failed to document a reason for the missed doses. Resident #56: Omeprazole (Prilosec) 20mg, one tablet by mouth twice a day (for heartburn). The November 2009 MAR documented the resident received only one tablet once a day from 11/8/09 through 11/18/09. The physician's order for the medication, dated 9/20/09, was for 20 mg two times a day. Resident #61: Tessalon Perles 100 mg, one tablet by mouth three times a day (to treat a cough). The medication technicians documented that the resident missed three PM doses of the medication by circling their initials on the November 2009 MAR on 11/8/09, 11/9/09 and 11/11/09. The medication technicians failed to document a reason for the missed doses.	Y 878		

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Y 878	Continued From page 21 The medication technicians left the November 2009 MAR blank for five PM doses on 11/8/09. 11/9/09, 11/10/09, 11/13/09 and 11/14/09. Without documentation, it is not clear whether the medication was also unavailable on these dates or was not given for some other reason. Resident #62: ASA 81 mg, one tablet every day at bedtime (blood thinner). The medication technicians documented that the resident missed eight doses of the medication by circling their initials on the November 2009 MAR on 11/8/09, 11/9/09, 11/10/09, 11/13/09, 11/14/09, 11/15/09, 11/16/09 and 11/17/09. The medication technicians failed to document a reason for the missed doses. Resident #66: Metformin HCL 500 mg, one tablet twice a day at 10:30 AM and 5:00 PM (for diabetes). The medication technicians documented that the resident missed three doses of the medication at 5:00 PM by circling their initials on the November 2009 MAR on 11/8/09, 11/17/09, and 11/18/09. The medication technicians failed to document a reason for the missed doses. Flomax 0.4 mg, one tablet every evening (benign hyperplasia of the prostate). The medication technicians documented that the resident missed two doses of the medication by circling their initials on the November 2009 MAR on 11/8/09 and 11/18/09. The medication technicians failed to document a reason for the missed doses. Seroquel 25 mg, two tablets at bedtime (for	Y 878		

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Y 878	Continued From page 22 bipolar disorder and schizophrenia). The medication technicians documented that the resident missed two doses of the medication by circling their initials on the November 2009 MAR on 11/17/09 and 11/18/09. The medication technicians failed to document a reason for the missed doses. Erythromycin 0.05, apply in each eye at 5:00 PM and bedtime (antibiotic). The medication technicians documented that the resident missed 22 doses of the 5:00 PM and bedtime medication by circling their initials on the November 2009 MAR from 11/8/09 through 11/18/09. The medication technicians failed to document a reason for the missed doses. Interview with medication technician, Employee #60, on 11/19/09 at 10:54 AM, revealed the medication was not available in the facility on 11/19/09. Resident #70: Lisinopril 5 mg, one tablet every day (to lower blood pressure). The medication technicians documented that the resident missed two doses of the medication by circling their initials on the November 2009 MAR on 11/11/09 and 11/12/09. The medication technicians failed to document a reason for the missed doses. Furosemide (Lasix) 40 mg, one time daily (diuretic). The medication technicians documented that the resident missed nine doses of the medication by circling their initials on the November 2009 MAR on 11/8/09, 11/10/09, 11/11/09, 11/12/09, 11/13/09, 11/14/09, 11/15/09, 11/16/09 and 11/17/09. The medication technicians failed to	Y 878		

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Y 878	Continued From page 23 document a reason for the missed doses. Iron 325 mg, one time daily. The medication technicians documented that the resident missed seven doses of the medication by circling their initials on the November 2009 MAR on 11/11/09 through 11/17/09. The medication technicians failed to document a reason for the missed doses. Resident #80: Flonase 50 micrograms (mcg), two sprays to each nostril every day (nasal congestion). The medication technicians left the November 2009 MAR blank on 11/18/09. Interview with the medication technician, Employee #45, revealed the medication was unavailable. Resident #88: Seroquel 25 mg, one tablet daily (for schizophrenia and bipolar disorder). The medication technicians documented on the November 2009 MAR that the medication was not available in the facility for one dose on 11/11/09. Resident #89: Seroquel 25 mg, one tablet at night (for schizophrenia and bipolar disorder). The medication technicians documented on the November 2009 MAR that the medication was not available from 11/1-12/09. The resident missed a total of 12 doses of the medication. Galanthamine Hydrobromide 4 mg, one tablet twice a day at 7:30 AM and 4:30 PM (for mild to moderate Alzheimer's dementia).	Y 878		

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Y 878	Continued From page 24 The medication technicians documented that the resident missed two 4:30 PM doses of the medication by circling their initials on the November 2009 MAR on 11/9/09 and 11/10/09. The medication technicians failed to document a reason for the missed doses. Hydrocortisone Valerate External Cream 2%, apply to left ear canal twice a day AM and PM (a corticosteroid). The medication technicians documented that the resident missed two PM doses of the medication by circling their initials on the November 2009 MAR on 11/10/09 and 11/13/09. The medication technicians failed to document a reason for the missed doses. Namenda 10 mg, one tablet twice a day at 9:00 AM and 5:00 PM (for dementia associated with Alzheimer's disease). The medication technicians documented that the resident missed two 5:00 PM doses of the medication by circling their initials on the November 2009 MAR on 11/10/09 and 11/13/09. The medication technicians failed to document a reason for the missed doses. Resident #91: Lidoderm Patch cut patch in ½ and apply ½ to right hip and ½ to right buttock each day (for pain). The medication technicians left the November 2009 MAR blank for 11 doses from 11/8/09 and 11/18/09. During an interview with the Wellness Director, Employee #2, she stated the medication technicians were not applying the patches daily because they thought the order was "as-needed" for pain.	Y 878		

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Y 878	Continued From page 25 Resident #93: Dilantin 125 mg/5 ml, 5 ml three times a day (for seizures). The medication technicians documented on the November 2009 MAR that they were giving the resident 10 ml of Dilantin two times a day, for a total of 20 mg of Dilantin. The resident's physician prescribed 5 ml of Dilantin three times a day, for a total of 15 ml. The facility was overmedicating the resident by 5 ml. Resident #94: APAP (Tylenol) 500 mg, two tablets every morning (for pain). The medication technicians documented on the November 2009 MAR that they were giving the resident two tablets every morning. The medication bottle label and the physician's order showed the medication was to be given every six hours "as needed" for pain. Resident #105: Coumadin 6 mg, ½ tablet every day at 5:00 PM (blood thinner). The medication technicians documented on the November 2009 MAR that the medication was not available in the facility for six doses 11/6/09 through 11/11/09. Resident #107: APAP (Tylenol) 325 mg, one tablet by mouth every four hours (for pain). The medication observed in the facility was Tylenol 650 mg. The medication technician interviewed reported the resident was being given 650 mg every four hours. The physician's order	Y 878		

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Y 878	Continued From page 26 was for Tylenol 325 mg, one tablet every four hours "as needed". The facility was giving the resident the wrong dosage of the medication and was not following the "as needed" order. This is a repeat deficiency from the 2/5/09 State Licensure survey, the 9/24/09 complaint investigation and the 11/2/09 complaint investigation. Severity: 3 Scope: 2	Y 878		
Y 879 SS=D	449.2742(6)(a)(2) Medication / Change order NAC 449.2742 6. Except as otherwise provided in this subsection, a medication prescribed by a physician must be administered as prescribed by the physician. If a physician orders a change in the amount or times medication is to be administered to a resident: (a) The caregiver responsible for assisting in the administration of the medication shall: (2) Indicate on the container of the medication that a change has occurred. This Regulation is not met as evidenced by: Surveyor: 28276 Based on record review and interview on 11/18/09 and 11/19/09, the facility failed to indicate a change on the container of the medication when a change occurred for 7 of 78 Residents (Resident #2, #7, #14, #20, #25, #41 and #84).	Y 879		

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Y 879	Continued From page 27 Findings include: Resident #2 was prescribed Tylenol 500 milligrams (mg) two tablets twice a day (for pain). The bottle documented Tylenol 500 mg one tablet twice a day. Resident #7 was prescribed Lisinopril 40 mg, one and a half tablets (=60 mg) every day (for blood pressure). The bottle documented Lisinopril 40 mg, ½ tablet every day. Resident #14 was prescribed Diphenoxylate/Atropine 2.5 mg, two tablets twice a day AM and PM (for diarrhea). The bottle documented one tablet twice a day "as needed" (PRN). Resident #20 was prescribed Torsemide 20 mg, one tablet every day (for high blood pressure). The bottle documented Torsemide 20 mg, one tablet by mouth twice a day. Resident #25 was prescribed Lactulose 10 grams (g)/15 milliliters (ml), 30 ml daily if no bowel movement for three days (for constipation). The bottle documented Lactulose 10g/15ml two tablespoons every day. Resident #41 was prescribed Cogentin .5 mg, two tablets at bedtime (to treat symptoms of Parkinson's disease). The bottle documented one tablet at bedtime. Resident #84 was prescribed Namenda 10 mg, one tablet twice a day. The bottle documented Namenda 10 mg, one tablet every day. Severity: 2 Scope: 1	Y 879		

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Y 883	Continued From page 28	Y 883		
Y 883 SS=D	449.2742(7) Medication / Resident Refusal NAC 449.2742 7. If a resident refuses, or otherwise misses, and administration of medication, a physician must be notified within 12 hours after the dose is refused or missed. This Regulation is not met as evidenced by: Surveyor: 28276 Based on record review and interview on 11/18/09 and 11/19/09, the facility failed to notify the physician for 2 of 78 residents who refused medications. Findings Include: Resident #9 - A medication technician reported the resident refused medications regularly. The medication technicians documented the resident refused medications 11/8/09 through 11/19/09, There was no evidence faxes were sent to the physician for the missed doses on 11/8/09, 11/10/09, 11/12/09, 11/14/09, 11/15/09 and 11/16/09. Resident #10 - The medication technicians documented that the resident refused Namenda 10 mg, one tablet by twice a day (AM and PM), on 11/14/09 PM and 11/16/09 PM. The facility had no evidence the physician was notified. The resident refused Docusate sodium 100 mg, one tablet three times a day (Am, Noon, PM), on 11/14/09 PM and 11/16/09 PM. The facility had	Y 883		

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CHANCELLOR GARDENS OF THE LAKE	2620 LAKE SAHARA DRIVE LAS VEGAS, NV 89117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 883	Continued From page 29 no evidence the physician was notified. Severity: 2 Scope: 1	Y 883		
Y 885 SS=F	449.2742(9) Medication / Destruction NAC 449.2742 9. If the medication of a resident is discontinued, the expiration date of the medication of a resident has passed, or a resident who has been discharged from the facility does not claim the medication, an employee of a residential facility shall destroy the medication, by an acceptable method of destruction, in the presence of a witness and note the destruction of the medication in the record maintained pursuant to NAC 449.2744. Flushing contents of vials, bottles or other containers into a toilet shall be deemed to be an acceptable method of destruction of medication. This Regulation is not met as evidenced by: Surveyor: 27364 Based on observation and record review on 11/18/09 and 11/19/09, the facility failed to destroy medications for 6 of 78 residents (Resident #11, #23, #42, #50. #82, and #89) and two discharged residents. Findings include: Resident #11's prescription for Tylenol changed from 325 milligrams (mg), two tablets every four hours as needed for pain, to Tylenol 500 mg one tablet every six hours as needed for pain. The	Y 885		

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Y 885	Continued From page 30 facility failed to destroy the old medication. Resident #23's Aerolizer found in the medication room refrigerator was expired. Resident #42's prescription for Levoxyl was changed from 125 micrograms (mcg), one tablet every day, to 100 mcg by mouth every day. The facility failed to destroy the old medication. Resident #50 was prescribed Loperamide 2 mg, one tablet every four hours for pain. The prescription was discontinued and the facility failed to destroy the medication. Resident #82 was prescribed Loratadine 10 mg, but the medication was discontinued. The facility failed to destroy the medication. Resident #89 was prescribed Levobunolol 0.25% one drop in both eyes daily. The medication on site at the facility was dated 5/19/09. The label documented "discard the medication 60 days after opening." Severity: 2 Scope: 1 Surveyor: 28276	Y 885		
Y 895 SS=E	449.2744(1)(b)(1) Medication / MAR NAC 449.2744 1. The administrator of a residential facility that provides assistance to residents in the administration of medication shall maintain: (b) A record of the medication administered to	Y 895		

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Y 895	Continued From page 31 each resident. The record must include: (1) The type of medication administered; (2) The date and time that the medication was administered; (3) The date and time that a resident refuses, or otherwise misses, an administration of medication; and (4) Instructions for administering the medication to the resident that reflect the current order or prescription of the resident's physician. This Regulation is not met as evidenced by: Surveyor: 28276 Based on record review on 11/18/09 and 11/19/09, the facility failed to ensure the medication administration record (MAR) was accurate for 18 of 78 residents (Resident #5, #23, #24, #30, #34, #41, #43, #47, #49, #50, #69, #72, #73, #83, #88, #89, #96, and #104). Findings include: Resident #5 was prescribed: -Plavix 75 milligrams (mg) one tablet every day in the AM (a blood thinner). The November 2009 medication administration record (MAR) documented Plavix 75 mg one tablet by mouth every other day. The medication technicians documented the medication was given every day. The MAR needs to be updated to reflect the current order. - Carisoprodol 350 mg one tablet three times a	Y 895		

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Y 895	Continued From page 32 day at AM, Noon and PM (a muscle relaxant). The November 2009 MAR was left blank for one dose on 11/12/09 (Noon). Resident #23 was prescribed: -Ferrous Sulfate 325 mg one tablet twice a day AM and PM (for iron deficiency). The November 2009 MAR was left blank for one dose on 11/17/09 PM. -Omeprazole 20 mg one tablet at bedtime (to prevent ulcers). November 2009 MAR was left blank for one dose 11/17/09. -Gabapentin 100 mg one tablet three times a day at 8:00 AM, 12:00 PM and 5:00 PM (for pain). The November 2009 MAR was left blank for one 5:00 PM dose on 11/17/09. -Docusate Sodium 100 mg one capsule twice a day AM and PM (for constipation). The November 2009 MAR was left blank for one PM dose on 11/17/09. -Namenda 10 mg one tablet twice a day at 8:00 AM and 5:00 PM (for dementia). The November 2009 MAR was left blank for one 5:00 PM dose on 11/17/09. -Simvastatin 10 mg one tablet at bedtime (for high cholesterol). The November 2009 MAR was left blank for one dose on 11/17/09. -Dilantin 100 mg three tablets by mouth at bedtime (for seizures). The November 2009 MAR was left blank for one dose on 11/17/09. Resident #24 was prescribed: -Furosemide 40 mg, one tablet twice a day. The facility documented the resident went to the hospital 11/10/09. The medication technician signed the MAR for Furosemide on 11/12/09. Resident #30 was prescribed: -Promethazine 25 mg, ½ tablet every six hours "as needed" (PRN). The medication was not	Y 895		

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Y 895	Continued From page 33 listed on the November 2009 MAR. -Temazepam 15 mg, one tablet every night PRN. The medication was not listed on the November 2009 MAR. Resident #34 was prescribed: -Phenobarbital 30 mg, two tablets twice a day at 9:00 AM and 5:00 PM (a sleep aid). The November 2009 MAR was left blank for one 5:00 PM dose on 11/17/09. Resident #41 was prescribed: -Clonazepam .5 mg, one tablet twice a day AM and 5:00 PM. The November 2009 MAR was left blank for one PM dose on 11/17/09. -Divalproex Sodium 500 mg, one tablet twice a day AM and PM. The November 2009 MAR was left blank for one PM dose on 11/17/09. -Lisinopril 40 mg, one tablet at bedtime. The November 2009 MAR was left blank for one dose on 11/17/09. -Seroquel 100 mg, one tablet at bedtime. The November 2009 MAR was left blank for one dose on 11/17/09. Resident #43 was prescribed: -Exelon Patch 4.6 mg, one to skin every day (for dementia). There was a discrepancy between what was listed on the November 2009 MAR and the medication available at the facility which was Exelon Patch 9.5 mg, one patch to skin every day. A medication review dated 10/23/09 showed the resident was prescribed "Exelon Patch 4.6 mg." The pharmacy reported the resident's physician changed the dosage to 9.5 mg on 10/23/09, so the facility had the correct medication but had not updated the resident's MAR. -Trazodone 50 mg, one tablet at bedtime. The	Y 895		

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Y 895	Continued From page 34 November 2009 MAR was left blank for one dose on 11/17/09. -Doxazosin 2 mg, one tablet by mouth at bedtime. The November 2009 MAR was left blank for one dose on 11/17/09. Resident #47 was prescribed: -Propranolol 60 mg, one tablet every day AM. The November 2009 MAR was left blank for one dose on 11/12/09. -Levothyroxine .075 mg, one tablet every day. The November 2009 MAR was left blank for one dose on 11/12/09. Resident #49 was prescribed: -Tylenol 500 mg, two tablets twice a day AM and PM. The November 2009 MAR was left blank for eight AM doses of the medication on 11/8/09, 11/9/09, 11/10/09, 11/11/09, 11/12/09, 11/16/09, 11/17/09 and 11/18/09. Resident #50 was prescribed: -Alprazolam .25 mg, one tablet at bedtime PRN. The medication was not listed on the November 2009 MAR. Resident #69 was prescribed: -Tylenol 500 mg, one tablet three times a day at 8:00 AM, 12:00 PM, and 5:00 PM. The November 2009 MAR was left blank for one 12:00 PM dose on 11/18/09. Resident #72 was prescribed: -Lyrica 75 mg, one tablet three times a day at AM, Noon and PM. The November 2009 MAR was left blank for one PM dose on 11/17/09. -Oxcarbazepine 150 mg, one tab by mouth twice a day AM and PM. The November 2009 MAR was left blank for six PM doses on 11/10/09, 11/13/09, 11/14/09, 11/15/09, 11/16/09, and	Y 895		

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Y 895	Continued From page 35 11/17/09. -Lamotrigine 100 mg, one tablet three times a day AM, Noon and PM. The November 2009 MAR was left blank for one AM dose on 11/11/09 and seven PM doses on 11/10/09, 11/13/09, 11/14/09, 11/15/09, 11/16/09, 11/17/09 and 11/18/09. -ASA 325 mg, one tablet every day in the AM. The November 2009 MAR was left blank for one dose on 11/11/09. -Amiodarone 200 mg, one tablet by mouth daily AM. The November 2009 MAR was left blank on 11/8/09, 11/9/09, 11/10/09, 11/11/09, 11/16/09, 11/17/09, 11/18/09 and 11/19/09. -Triamterene-HCTZ 25 mg, one tablet daily AM. The November 2009 MAR was left blank for two doses on 11/17/09 and 11/18/09. -Colace 100 mg, one tablet daily AM. The November 2009 MAR was left blank for three doses on 11/16/09, 11/17/09 and 11/18/09. -Lisinopril 5 mg, one tablet daily AM. The November 2009 MAR was left blank for three doses on 11/16/09, 11/17/09 and 11/18/09. Resident #73 was prescribed: -Tricor 145 mg, every day. The November 2009 MAR was left blank for one dose on 11/11/09. -Mentax every day. The November 2009 MAR was left blank for one dose on 11/11/09. -ASA 81 mg. The November 2009 MAR was left blank for two doses on 11/12/09 and 11/13/09. -Plavix 75 mg. The November 2009 MAR was left blank for one dose on 11/11/09. -Galanthamine ER twice a day. The November 2009 MAR was left blank for six doses on 11/11/09, 11/12/09 and 11/13/09. -Namenda 10 mg, one tablet twice a day. The November 2009 MAR was left blank for two doses on 11/12/09. -Norvasc 10 mg, one tablet every day in the	Y 895		

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Y 895	Continued From page 36	Y 895		

morning. The November 2009 MAR was left blank for one dose on 11/11/09.
-Advair. The November 2009 MAR was left blank on 11/11/09 and 11/12/09.

Resident #83 was prescribed:
-Calcium + Vitamin D 600 mg, one tablet by mouth twice a day AM and PM. The November 2009 MAR was left blank for one PM dose 11/18/09.
-Ensure supplement drink one can three times a day AM, 12:00 PM, and PM. The November 2009 MAR was left blank for one PM dose 11/18/09.

Resident #88 was prescribed:
-Temazepam 30 mg, one tablet by mouth at bedtime. The medication was not listed on the November 2009 MAR.

Resident #89 was prescribed:
-Levobunolol 0.25%, one drop in both eyes daily. The November 2009 MAR was blank for 10 doses on 11/9/09, 11/10/09, 11/11/09, 11/12/09, 11/13/09, 11/14/09, 11/15/09, 11/16/09, 11/17/09 and 11/18/09.
-Metoclopramide 10 mg, one tablet before meals and at bedtime. The medication was not listed on the November 2009 MAR.
- Promethazine 25 mg, 1/2 tablet four times a day PRN. The medication was not listed on the November 2009 MAR.

Resident #96 was prescribed:
-Diovan HCL 160/25, take one tablet by mouth every day in the morning. The November 2009 MAR was blank for one dose on 11/19/09.

Resident #104 was prescribed:
-Senokot 8.6 mg, two tablets at bedtime. The

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Y 895	Continued From page 37 November 2009 MAR was blank for one dose on 11/18/09. - Colace 100 mg, one capsule twice a day AM and PM. The November 2009 MAR was blank for one dose PM dose on 11/18/09. -Neurontin 300 mg, one capsule three times a day AM, 12:00 PM, PM. The November 2009 MAR was blank for one 12:00 PM dose on 11/18/09, and two PM doses on 11/14/09 and 11/18/09. This was a repeat deficiency from the 9/24/09 and 11/2/09 Complaint Investigations. Severity: 2 Scope: 2	Y 895		
Y 920 SS=F	449.2748(1) Medication Storage NAC 449.2748 1. Medication, including, without limitation, any over-the-counter medication, stored at a residential facility must be stored in a locked area that is cool and dry. The caregivers employed by the facility shall ensure that any medication or medical or diagnostic equipment that may be misused or appropriated by a resident or any other unauthorized person is protected. Medication for external use only must be kept in a locked area separate from other medications. A resident who is capable of administering medication to himself without supervision may keep his medication in his room if the medication is kept in a locked container for which the facility has been provided a key.	Y 920		

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Y 920	Continued From page 38 This Regulation is not met as evidenced by: Surveyor: 27364 Based on observation on 11/19/09, the facility failed to ensure the central medication room was secured at all times. Severity: 2 Scope 3	Y 920		
Y 930 SS=C	449.2749(1)(a) Resident File-Storage, Res Information NAC 449.2749 1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he permanently leaves the facility. The file must be kept locked in a place that is resistant to fire and is protected against unauthorized use. The file must contain all records, letters, assessments, medical information and any other information related to the resident, including without limitation: (a) The full name, address, date of birth and social security number of the resident. This Regulation is not met as evidenced by: Surveyor: 27364 Based on observation on 11/19/09, the facility failed to ensure the resident files for 82 of 82 assisted living residents were kept secured. Findings include:	Y 930		

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Y 930	Continued From page 39 On 11/19/09 at 6:50 AM and 12:54 PM, the resident's files were observed unattended in the unlocked central medication room. Severity: 1 Scope: 3	Y 930		
Y 936 SS=F	449.2749(1)(e) Resident file-NRS 441A Tuberculosis NAC 449.2749 1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he permanently leaves the facility. The file must be kept locked in a place that is resistant to fire and is protected against unauthorized use. The file must contain all records, letters, assessments, medical information and any other information related to the resident, including without limitation: (e) Evidence of compliance with the provisions of chapter 441A of NRS and the regulations adopted pursuant thereto. This Regulation is not met as evidenced by: Surveyor: 28276 Based on record review on 11/18/09 and 11/19/09, the facility failed to ensure 38 of 110 residents complied with NAC 441A.380 regarding tuberculosis testing (Resident #1, #2, #3, #6, #7, #15, #12, #17, #26, #29, #38, #39, #40, #42, #44, #47, #50, #54, #55, #58, #59, #62, #68, #69, #70, #71, #72, #73, #79, #82, #87, #88, #91, #92, #93, #96, #100 and #102) which affected all residents. Findings Include:	Y 936		

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Y 936	Continued From page 40 The file for Resident #1, #2, #6, #7, #12, #26, #38, #39, #40, #42, #50, #58, #72, #73, #87, #88, #92 and #96 failed to provide documentation of a two step tuberculosis (TB) test. The file for Resident #3, #15, #44, #54, #59, #68, #69, #70, #79, #82, #91 and #100 failed to provide documentation of an annual TB test. The file for Resident #17 provided documentation of a two-step TB test in June of 2008, but no 2009 annual TB test. Resident #17 needs a two-step TB test to be in compliance with TB testing requirements. The file for Resident #29 provided documentation of an initial one step TB test in May of 2009, but no second step. The file for Resident #47 provided documentation of an initial one step TB test in October of 2009, but no second step. The file for Resident #55 provided documentation of an initial one step TB test in August of 2009, but no second step. The file for Resident #62 provided documentation of TB signs and symptoms review dated 6/23/09, the file did not contain evidence the resident tested positive for TB on a skin test or evidence of a negative chest x-ray. The file for Resident #71 provided documentation of an initial one step TB test in September of 2009, but no second step. The file for Resident #93 provided documentation of an initial one step TB test in May of 2009, but no second step.	Y 936		

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Y 936	Continued From page 41 The file for Resident #102 provided documentation of an initial one step TB test in May of 2009, but no second step. This was a repeat deficiency from the 2/5/09 State Licensure survey. Severity: 2 Scope: 3	Y 936		
Y 991 SS=F	449.2756(1)(b) Alzheimer's Fac door alarm NAC 449.2756 1. The administrator of a residential facility which provides care to persons with Alzheimer's disease shall ensure that: (b) Operational alarms, buzzers, horns or other audible devices which are activated when a door is opened are installed on all doors that may be used to exit the facility. This Regulation is not met as evidenced by: Surveyor: 27364 Based on observation on 11/18/09, the facility failed to ensure 1 of 3 of doors that allowed exiting from the Memory Care Unit had alarms that operated when the exit door was opened (Patio exit door). This is a repeat deficiency from the 2/5/09 annual State Licensure survey. Severity: 2 Scope: 3	Y 991		

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Y 994	Continued From page 42	Y 994		
Y 994 SS=F	449.2756(1)(e) Alz fac -Dangerous items NAC 449.2756 1. The administrator of a residential facility which provides care to persons with Alzheimer's disease shall ensure that: (e) Knives, matches, firearms, tools and other items that could constitute a danger to the residents of the facility are inaccessible to the residents. This Regulation is not met as evidenced by: Surveyor: 27364 Based on observation on 11/18/09, the facility failed to ensure dangerous items were not accessible to 27 of 27 residents in the Memory Care Unit. Findings include: Six serrated knives were stored in an unsecured drawer in the kitchen area. Severity: 2 Scope: 3	Y 994		
Y 998 SS=F	449.2756(f)(4) Alzheimer's Facility-Yard safe NAC 449.2756 1. The administrator of a residential facility which provides care to persons with Alzheimer's disease shall ensure that: (f) The facility has an area outside the facility or a yard adjacent to the facility that: (4) Is maintained in a manner that does not	Y 998		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2489AGC	A. BUILDING _____ B. WING _____	11/19/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHANCELLOR GARDENS OF THE LAKE	2620 LAKE SAHARA DRIVE LAS VEGAS, NV 89117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 998	Continued From page 43 jeopardize the safety of the residents. All gates leading from the secured, fenced area or yard to an unsecured open area or yard must be locked and keys for gates must be readily available to the members of the staff of the facility at all times. This Regulation is not met as evidenced by: Surveyor: 27364 Based on observation on 11/18/09 and 11/19/09, the facility failed to ensure the yard adjacent to the facility was maintained in a safe manner. Findings include: On 11/18/09, two chairs were observed next to the perimeter fence surrounding the Alzheimer's exterior yard. With the chairs positioned next to the fence, it decreased the distance to the top of the fence by four feet facilitating an Alzheimer's residents ability to depart from the facility by climbing over the fence. This is a repeat deficiency from the 10/20/09 - 11/2/09 complaint investigation. Severity: 2 Scope: 3	Y 998		